

CERTIFICATE OF DEATH

10236

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> (4) <u>0355.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Schafer's Convalescent Retreat</u>		d. STREET ADDRESS <u>1737 Joan Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Bennett</u> Last <u>Bennett</u>		4. DATE OF DEATH Month <u>September</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Bennett</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Revell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Edward J. Smith, 1737 Joan Avenue</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>57</u> , to <u>Sept. 21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 20</u> , 19 <u>58</u> , and that death occurred at <u>6 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John G. Kochman</u>		DATE SIGNED <u>9/22/58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. L. A. Kochman</u>		ADDRESS (Street, city or town, state) <u>1214 N. CALVERT ST</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9-24-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook-Blight, Inc.</u>		24a. REC'D BY REGISTRAR <u>SEP 29 '58</u>	
ADDRESS <u>6009 Harford Road</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	
<u>Baltimore 14, Md.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, date of death, and cause of death. The form is divided into several horizontal sections with labels for each field.

NAME: \_\_\_\_\_

AGE: \_\_\_\_\_

SEX: \_\_\_\_\_

DATE OF DEATH: \_\_\_\_\_

PLACE OF DEATH: \_\_\_\_\_

Cause of Death: \_\_\_\_\_

Signature: \_\_\_\_\_

Official Seal: \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

10237

10247

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> c. LENGTH OF STAY IN It <b>90</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shaffers Convalescent Retreat</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>MARYLAND</b> <b>Penna</b> b. COUNTY <b>Philadelpha</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Philadelphia</b> d. STREET ADDRESS <b>1837 N. Camac</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARTHA</b> Middle <b>COLEMAN</b> Last 4. DATE OF DEATH Month <b>Sept.</b> Day <b>15</b> Year <b>1958</b>				5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>3-12-1872</b> 9. AGE (In years last birthday) <b>86</b> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b> 11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b> 12. CITIZEN OF WHAT COUNTRY? <b>None</b>			
13. FATHER'S NAME <b>Richard Coleman</b> 14. MOTHER'S MAIDEN NAME <b>Jenina J. Jones</b> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> 16. SOCIAL SECURITY NO. <b>None</b> 17. INFORMANT <b>Miss Edith V. Coleman, Philadelphia, Pa</b> Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> (c) <b>10 yr.</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 da.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>9-5</b> 19 <b>58</b> to <b>9-15</b> 19 <b>58</b> , that I last saw the deceased alive on <b>9-9</b> 19 <b>58</b> , and that death occurred at <b>5:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Thomas F. Herbert</b> M.D. <b>Ellicott City, Md</b> <b>9/15/58</b> PHYSICIAN'S NAME (Type) <b>Thomas F. Herbert, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>Sept. 17 1958</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b> 22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>				23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b> ADDRESS 24a. REC'D BY REGISTRAR DATE <b>SEP 16 '58</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

CERTIFICATE OF DEATH

1917

NAME OF DECEASED: John J. Smith

AGE: 45 YEARS

SEX: Male

RACE: White

DATE OF DEATH: Jan 15 1917

PLACE OF DEATH: Home

Cause of Death: Heart Disease

Signature of Physician: [Signature]

Signature of Registrar: [Signature]

TO BE FILLED BY THE REGISTRAR

FOR STATE  
HEALTH DEPT.

Item 206, d, MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Film 249, 10/13/59-AM 3  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10238

10248

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harwood (Elkridge P.O.)</b>		c. LENGTH OF STAY IN Tb		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 16</b>		d. STREET ADDRESS <b>3824 Bonner Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt. 1 1 1/2 mile south of intersection 477</b>		Rt		4. DATE OF DEATH Month Day Year <b>September 20, 1958 19</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-5-1938</b>									
3. NAME OF DECEASED (Type or print) <b>GEORGE CHARLES FLORES</b>		First Middle Last		9. AGE (In years last birthday) <b>19 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>		11. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>		12. BIRTHPLACE (State or foreign country) <b>Baltimore, MD.</b>		13. CITIZEN OF WHAT COUNTRY?									
14. FATHER'S NAME <b>Charles Flores</b>		15. MOTHER'S MAIDEN NAME <b>Brown</b>		16. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes</b>		17. SOCIAL SECURITY NO. <b>216-26-7597</b>		18. INFORMANT <b>Mrs. George Flores, Baltimore, Md</b>		Address											
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>830x</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Compound fracture of skull</b> (c) <b>Instant</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Reckless driving; standing at gas pump struck by swerving car</b>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>4-50 p. m. 9-20-58 19</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Gas station</b>		20f. (City or town) <b>Harwood</b>		20g. (County) <b>Howard</b>		20h. (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <b>George E. Burgtorf</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>9-20-58</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-23-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greek</b>		22d. LOCATION (City, town, or county) <b>Balto - md</b>		22e. (State) <b>Md</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Lambros funeral Home Inc North A</b>		ADDRESS <b>440 E.</b>		24a. REC'D BY REGISTRAR <b>SEP 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kane</b>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATEMENT OF DEATH  
MEDICAL EXAMINER'S REPORT

FILE NO.

1. Name of Deceased: \_\_\_\_\_  
2. Sex: \_\_\_\_\_  
3. Age: \_\_\_\_\_  
4. Date of Death: \_\_\_\_\_  
5. Place of Death: \_\_\_\_\_  
6. Cause of Death: \_\_\_\_\_  
7. Manner of Death: \_\_\_\_\_  
8. Signature of Medical Examiner: \_\_\_\_\_  
9. Date of Report: \_\_\_\_\_

10. Signature of Coroner: \_\_\_\_\_  
11. Date of Report: \_\_\_\_\_  
12. Signature of Medical Examiner: \_\_\_\_\_  
13. Date of Report: \_\_\_\_\_  
14. Signature of Medical Examiner: \_\_\_\_\_  
15. Date of Report: \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10249

## CERTIFICATE OF DEATH

Reg. Dist. No.

10239

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. LENGTH OF STAY IN 1b <b>1 yr.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City, Md.</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>21 Avoca Ave.</b>	
d. STREET ADDRESS <b>21 Avoca Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mamie</b> Middle <b>H.</b> Last <b>Humbert</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>29</b> Year <b>58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 19, 1882</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Oakland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John O. Michael</b>		14. MOTHER'S MAIDEN NAME <b>Lavinia Michael</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Edward M. Humbert, 21 Avoca Ave. Ellicott City Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardio-vascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a. 11.</b> Month, Day, Year <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 6,</b> 19 <b>53</b> , to <b>Sept. 29,</b> 19 <b>58</b> , that I last saw the deceased alive on <b>Sept. 28,</b> 19 <b>58</b> , and that death occurred at <b>6:05 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4116 Edmondson Avenue</b> DATE SIGNED <b>9/29/58</b> ACTUAL SIGNATURE <b>Harry L. Knipp</b> M.D. <b>4116 Edmondson Avenue</b> PHYSICIAN'S NAME (Type) <b>4116 Edmondson Avenue</b> <b>Harry L. Knipp, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 2/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore 29, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. L. Keene</b>		ADDRESS <b>4101 Edmondson Ave.</b>	
24a. REC'D BY REGISTRAR DATE <b>OCT 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

CERTIFICATE OF DEATH

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fullerton, Md.</b> <b>03X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Taylor Manor Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Caroline</b> Middle <b>C.</b> Last <b>Schott</b>		4. DATE OF DEATH Month <b>Sept</b> Day <b>26</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/22/89</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b>	IF UNDER 24 HRS. Hours <b>68</b> Min. <b>68</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (State or foreign country) <b>Fullerton, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Charles Schott</b>	
14. MOTHER'S MAIDEN NAME <b>Bertha Stettler</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John Schott Box 201 Cross Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Branchopneumonia, left upper lobe</b> (c) <b>7 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arterio sclerosis, severe. Chronic brain syndrome &amp; psychosis, organic</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 13, 1958</b> , to <b>Sept 26, 1958</b> , that I last saw the deceased alive on <b>Sept 26, 1958</b> , and that death occurred at <b>11:05 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Taylor Manor Hospital</b> DATE SIGNED <b>9/26/58</b>			
ACTUAL SIGNATURE <b>Stephen Lee Magness</b>		M.D. <b>Taylor Manor Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Stephen Lee Magness, M.D. Tayoor Manor Hosp, Ellicott City, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-29-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's</b>	22d. LOCATION (City, town, or county) (State) <b>Belair Rd. Fullerton, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Essahn Funeral Home</b>		ADDRESS <b>7401 Belair Rd.</b>	
24a. RECEIVED BY REGISTRAR DATE <b>Oct 1 58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10251

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenwood</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RAYMOND LEE SMALLWOOD Sr.</u>		4. DATE OF DEATH Month Day Year <u>9-27-58</u> <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-24-1895</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grist Mill</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Howard Co Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William W. Smallwood</u>		14. MOTHER'S MAIDEN NAME <u>Florence Iglehart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>217-34-5142</u>	
17. INFORMANT <u>Mrs. Irene Smallwood, Glenwood, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary artery occlusion</u>			
420.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles S. Whitaker,</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles S. Whitaker, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Howard County</u>		DATE SIGNED <u>9-28-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-30-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham, Ellicott City, Md</u>		24a. REC'D BY REGISTRAR <u>SEP 30 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hines</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10252

CERTIFICATE OF DEATH

Reg. Dist. No.

10242  
195

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>				c. LENGTH OF STAY IN 1b <u>40 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>76 Washington Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
II NAME OF DECEASED (Type or print) First Middle Last <u>Howard</u> <u>Teal</u>				4. DATE OF DEATH Month Day Year <u>September 30 1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 8, 1880</u> 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>matchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>mill</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-01-7704</u>		17. INFORMANT Address <u>Miss Howard Teal, Savage, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO (b) <u>Hypertensive Cardio-Vas. Disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>2 yrs</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Instantly</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10/1/56</u> , 19 <u>56</u> , to <u>9/30/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/30/58</u> , 19 <u>58</u> , and that death occurred at <u>7 A.</u> M, from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Frank E. Shipley</u> M.D.						ADDRESS (Street, city or town, state) <u>10/1/58</u>	
PHYSICIAN'S NAME (Type) <u>Frank E. Shipley, M.D., Savage, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 3, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Savage Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Savage, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McWitt Handman, Laurel, Md</u>				ADDRESS <u>Laurel, Md</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 6 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. L. &amp; K. H.</u>			



10253

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rt. 32</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WALTER B.</b> Middle <b>WALLICH</b> Last <b></b>				4. DATE OF DEATH Month <b>9-27-58</b> Day <b></b> Year <b>19</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-10-1878</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>		11. BIRTHPLACE (State or foreign country) <b>Fulton, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b></b>	
13. FATHER'S NAME <b>Winfield Wallich</b>				14. MOTHER'S MAIDEN NAME <b>Kate Simpson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Ellsworth Wallich, Clarksville, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>instant.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <b>5-19-</b> 19 <b>46</b> , to <b>9-27-</b> 19 <b>58</b> , that I last saw the deceased alive on <b>9-24-</b> 19 <b>58</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Clarksville, Md.</b> DATE SIGNED <b>9-28-58</b>							
ACTUAL SIGNATURE <b>Charles S. Whitaker</b> M.D.		PHYSICIAN'S NAME (Type) <b>Charles S. Whitaker, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-30-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt Zion</b>		22d. LOCATION (City, town, or county) <b>Highland, Md</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 30 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth	
6. Date of death		7. Time of death		8. Cause of death		9. Place of death		10. Signature of physician	
11. Signature of registrar		12. Signature of informant		13. Signature of witness		14. Signature of funeral director		15. Signature of undertaker	
16. Signature of coroner		17. Signature of justice of the peace		18. Signature of town clerk		19. Signature of selectmen		20. Signature of board of health	
21. Signature of board of registration		22. Signature of board of health		23. Signature of board of education		24. Signature of board of selectmen		25. Signature of board of trustees	
26. Signature of board of supervisors		27. Signature of board of assessors		28. Signature of board of commissioners		29. Signature of board of officers		30. Signature of board of directors	
31. Signature of board of managers		32. Signature of board of trustees		33. Signature of board of directors		34. Signature of board of officers		35. Signature of board of managers	
36. Signature of board of trustees		37. Signature of board of directors		38. Signature of board of officers		39. Signature of board of managers		40. Signature of board of trustees	
41. Signature of board of directors		42. Signature of board of officers		43. Signature of board of managers		44. Signature of board of trustees		45. Signature of board of directors	
46. Signature of board of officers		47. Signature of board of managers		48. Signature of board of trustees		49. Signature of board of directors		50. Signature of board of officers	
51. Signature of board of managers		52. Signature of board of trustees		53. Signature of board of directors		54. Signature of board of officers		55. Signature of board of managers	
56. Signature of board of trustees		57. Signature of board of directors		58. Signature of board of officers		59. Signature of board of managers		60. Signature of board of trustees	
61. Signature of board of directors		62. Signature of board of officers		63. Signature of board of managers		64. Signature of board of trustees		65. Signature of board of directors	
66. Signature of board of officers		67. Signature of board of managers		68. Signature of board of trustees		69. Signature of board of directors		70. Signature of board of officers	
71. Signature of board of managers		72. Signature of board of trustees		73. Signature of board of directors		74. Signature of board of officers		75. Signature of board of managers	
76. Signature of board of trustees		77. Signature of board of directors		78. Signature of board of officers		79. Signature of board of managers		80. Signature of board of trustees	
81. Signature of board of directors		82. Signature of board of officers		83. Signature of board of managers		84. Signature of board of trustees		85. Signature of board of directors	
86. Signature of board of officers		87. Signature of board of managers		88. Signature of board of trustees		89. Signature of board of directors		90. Signature of board of officers	
91. Signature of board of managers		92. Signature of board of trustees		93. Signature of board of directors		94. Signature of board of officers		95. Signature of board of managers	
96. Signature of board of trustees		97. Signature of board of directors		98. Signature of board of officers		99. Signature of board of managers		100. Signature of board of trustees	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12, 13, 14, 23 Film G234 9-30-58 et

## CERTIFICATE OF DEATH

Reg. Dist. No. 10244

10254

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>				c. LENGTH OF STAY IN 1b <b>3 Y 01-4</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shaffers Nursing Home</b>				d. STREET ADDRESS <b>2132 E. Oliver St.</b>			
3. NAME OF DECEASED (Type or print) First <b>WALTER M.</b> Middle <b>WILHELM</b> Last <b></b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>13,</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>Unknown</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1, 1879</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT Address <b>Records Shaffers Nursing Home, Ellicott City, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>acute</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> Month <b></b> Day <b></b> Year <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b></b>		20g. (County) <b></b>	
20h. (State) <b></b>		21. I certify that I attended the deceased from <b>Jan 1</b> , 19 <b>57</b> , to <b>Sept. 13</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Sept. 12</b> , 19 <b>58</b> , and that death occurred at <b>6 A</b> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Dr. A. Kochman</b>		M.D. <b>1214 N. Calvert St.</b>		ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b>		DATE SIGNED <b>9/13/58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. A. Kochman</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b></b>	22b. DATE THEREOF <b>9.23.58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>U. of Md. Med. School</b>		22d. LOCATION (City, town, or county) <b>9.23.58</b>		(State) <b></b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Higgenbotham Funeral Home, Ellicott City,</b>				24a. REC'D BY REGISTRAR DATE <b>9.25.58</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Threlk</b>	
<b>Maryland</b>							

CERTIFICATE OF DEATH

1911

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1866		BALTIMORE, MD.	
MARRIED		WIFE		NAME		AGE		DATE OF MARRIAGE		PLACE OF MARRIAGE	
YES		MARY H. HARRIS		40		W		1871		BALTIMORE, MD.	
CAUSE OF DEATH		DISEASE		SYMPTOMS		TREATMENT		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		CORONARY ARTERY DISEASE		PAIN IN CHEST		MEDICINE		JANUARY 1, 1911		BALTIMORE, MD.	
TIME OF DEATH		HOUR		MINUTE		SECOND		DATE OF DEATH		PLACE OF DEATH	
10:00 AM		10		00		00		JANUARY 1, 1911		BALTIMORE, MD.	
SIGNATURE OF PHYSICIAN		NAME		ADDRESS		CITY		STATE		ZIP	
J. H. HARRIS		J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD.		21201	
SIGNATURE OF FUNERAL HOME		NAME		ADDRESS		CITY		STATE		ZIP	
J. H. HARRIS		J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD.		21201	

